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I. Reasonable Cost of Inpatient Hospital Services:

A. For each hospital also participating in the Health Insurance for the Aged program under Title XVIII of the Social Security Act, the State Agency will apply the same standards, cost reporting period, cost reimbursement principles, and method of cost apportionment currently used in computing reimbursement to such hospital under Title XVIII of the Act.

B. For each hospital not participating in the program under Title XVIII of the Act, the State Agency will apply the standards and principles described in 42 CFR 413.1 through 413.178, either (a) one of the available alternative cost apportionment methods in CFR 413.50, or (b) the "Gross RCCAC method" of cost apportionment.

C. The Department will provide for appropriate audit to assure that payments made to providers for inpatient and outpatient hospital services meet the requirements of reasonable cost.

D. For cost reporting periods ending before August 15, 1980, any determination of a cost settlement amount due to or from a hospital would be resolved by adjusting upward or downward the interim rate of payment for the subsequent period. For cost reporting periods ending on or after August 15, 1980, any determination of a cost settlement amount due would be resolved by a cash payment to or from the hospital. The HCFA Publication 15 (HIM-15) will be utilized for establishing the time at which such payment would be due.

E. The reimbursement methodology for inpatient hospital services described on Page 1, Paragraphs A through D, has been modified in accordance with a waiver authorized under Section 1115(a)(1) of the Social Security Act for the period January 1, 1981 through December 31, 1982. For hospitals subject to provisions of the waiver, effective for cost reporting periods beginning on or after January 1, 1981, reimbursement for inpatient hospital services will be made in accordance with this alternative system.

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F. The reimbursement methodology for inpatient hospital services provided by instate providers described in Paragraphs A through E has been modified in accordance with provisions of the Omnibus Reconciliation Act of 1981. For admissions on or after January 1, 1983, reimbursement will be based on the prospective reimbursement system, as referenced in the notice of authorization, and also described below beginning at Section IV of this statement.

G. Audited cost reports available to the Department for hospital fiscal years ending in 1980 will be used to initiate this plan.

I. Cost Finding and Cost Reporting

A. Each hospital participating in the Georgia Medicaid Hospital Program will submit a Uniform Cost Report postmarked no later than three (3) calendar months after the close of its cost reporting year. A hospital filing a certified cost report that has been audited by the independent auditors of the hospital will be given a 30-day extension if the Department is notified in writing that a certified report is being filed. The cost reporting period for the purpose of this plan shall be the same as that for the Title XVIII and Title V cost reporting, if applicable. A complete, legible copy of the cost report shall be submitted to the Medicare intermediary and to the Department as appropriate.

B. All hospitals are required to detail their costs for their entire reporting year making appropriate adjustments as required by this plan for determination of allowable costs. New hospitals must adhere to requirements of Section 2414.1 of HCFA Publication 15 (HIM-15). A prospective reimbursement rate, however, will not be established for a new hospital using a base period cost report of less than nine months. For a new general hospital with no cost history, the interim per case rate shall be the budgeted rate approved by the Department. Interim rates will be subject to a cost settlement for the interim rate period.

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C. The cost report must be prepared in accordance with the method of reimbursement and cost findings of Title XVIII (Medicare) Principles of Reimbursement described in 42 CFR 413, Subparts A, B, C, D, E, F and G, and further interpreted by HCFA Publication 15 (HIM-15) except as modified by this plan. Allowable costs will not include reasonable costs that are in excess of customary charges. Only nominal charge providers will be exempt from the lesser of costs or charges principle. A nominal charge provider is a public provider which charges patients based on their ability to pay. These are charges which are token in nature and are not intended to be full reimbursement for the items or services furnished.

D. A hospital must furnish its cost report within three months after its fiscal year end. If the report has not been received after this three-month period, a written warning will be issued. This warning will indicate that if, after an additional month (total four months), the cost report has not been received, a twenty percent reduction will be imposed on all payments made during that period that the cost report is late. These payments will be withheld until an acceptable Medicaid cost report is received. After the cost report is received and is determined to be acceptable, the withheld funds will be released. If the cost report is not received after another month (total five months from a hospital's fiscal year end) or a request for extension has not been granted, the hospital's agreement of participation will be subject to termination.

7/1/95 A hospital with a cost reporting period ending on or after June 27, 1995, must furnish its cost report within five months after its fiscal year end. If the report has not been received after this five-month period and a request for extension has not been granted, a written warning will be issued. This warning will indicate that if, after an additional month (total six months), the cost report has not been received, a one hundred percent reduction will be imposed on all payments made during that period that the cost report is late. These payments will be withheld until an acceptable Medicaid cost report is received. After the cost report is received and is determined to be acceptable, the withheld funds will be released. If the cost report is not received after seven months from the hospital's fiscal year end, the hospital's agreement of participation will be subject to termination.

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E. A hospital which voluntarily or involuntarily ceases to 7/1/95 participate in the Georgia Medicaid program or experiences a change of ownership must file a final cost report within five (5) months of the date of termination or change of ownership. For the purpose of this plan, filing a final cost report is not required when: 1) the capital stock of a corporation is sold without change in title to assets or 2) a partnership interest is sold as long as one of the original limited partners becomes a general partner, or control remains unchanged. Any change of ownership must be reported to the Department within 45 days after such change of ownership.

F. All hospitals are required to maintain a Medicaid Log and financial and statistical records in accordance with 42 CFR 413.20 and 413.24. For purposes of this plan, statistical records shall include beneficiaries' medical records. These records must be available upon request to representatives, employees or contractors of the Department, State Auditors, the General Accounting Office (GAO) or the United States Department of Health and Human Services (HHS).

G. Records of related organizations as defined by 42 CFR 413.17 must be available upon demand to representatives, employees or contractors of the Department, the Inspector General, GAO, or HHS.

H. The Department shall retain all uniform cost reports submitted for a period of at least three years following the date of submission of such reports and will maintain those reports pursuant to the record keeping requirements of 42 CFR 431.17. Access to submitted cost reports will be in conformity with Georgia law. Unless enjoined by a court of competent jurisdiction, the cost report will be released to the requestor.

III. Audits

A. Background

Medicaid (Title XIX), Maternal and Child Health and Crippled Children's Services (Title V), and Medicare (Title XVIII) have required that inpatient hospital services be reimbursed on a reasonable cost basis and the prospective system will be based upon audited costs. To

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assure that recognition of reasonable cost is being achieved, a comprehensive hospital audit program has been established. The hospital common audit program has been established to reduce the cost of auditing submitted cost reports under the above three programs and to avoid duplicate auditing effort. The purpose is to have one audit of a participating hospital which will serve the needs of all participating programs reimbursing the hospital for services rendered.

B. Common Audit Program

The Department has entered into a written agreement with the Georgia based Medicare intermediary for participation in a common audit program of Titles V, XVIII and XIX. Under this agreement, the intermediary shall provide the Department the result of desk review and field audits of those hospitals located in Georgia.

C. Other Hospital Audits

For those hospitals not covered by the common audit agreement with the Medicare intermediary, the Department shall be responsible for the performance of desk reviews and field audits, the Department shall:

1. Determine the scope and format for on-site audits.

2. Contract annually for the performance of desk reviews and audits.

3. Ensure all audits are performed in accordance with generally accepted auditing standards of the AICPA.

4. Ensure that only those expense items that the plan has specified as allowable costs under Section III of this plan have been included by the hospital in the computation of the costs of the various services provided under Title XIX in Georgia;

5. Review to determine that the Georgia Medicaid Log is properly maintained and current in those hospitals where its maintenance is required.

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6. Issue, upon the conclusion of each full scope audit, a report which shall meet generally accepted auditing standards and shall declare the auditor's opinion as to whether, in all material aspects, the cost submitted by a hospital meets the requirements of this plan.

D. Retention of Cost Reports

All audited cost reports received from the Medicare intermediary or issued by the Department will be kept in accordance with 42 CFR 431.17.

E. Overpayments and Underpayments

1. Overpayments which result from "final" settlement of cost reports will be reimbursable to the Department, as will overpayments attributable only to allowable costs.

2. Overpayments in outpatient hospital services will not be used to offset underpayments in inpatient hospital services, and conversely, overpayments in inpatient hospital services will not be used to offset underpayments in outpatient hospital services.

3. The final settlement amounts resulting from audits or desk reviews of cost reports for outpatient hospital services will be reported separately from those amounts for inpatient hospital services.

4. Any overpayment or underpayment that resulted from a rate adjustment due to an error in either reporting or calculation of the rate will be refunded to the Department or to the provider as appropriate.

5. Any overpayment or underpayment that resulted from a rate based on a budget will be refunded to the Department or to the provider as appropriate.

6. The Department may adjust the reimbursement of any provider whose rate is established specifically for it on the basis of cost reporting, whenever the Department determines that such adjustment is

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appropriate. The provider shall be notified in writing of the Department's intention to adjust the rate, either prospectively, retroactively or both.

7. The terms of payment will be in accordance with the Department's policy.

8. All overpayments will be reported by the Department to HCFA as required.

9. Information intentionally misrepresented by a hospital in the cost report shall be grounds to suspend the hospital from participation in the Georgia Medicaid Program.

IV. Allowable Costs

Allowable costs will be determined using Title XVIII (Medicare) Principles of Reimbursement and the guidelines in the HCFA Publication 15 (HIM-15) except as modified by Title XIX of the Act, this plan, requirements of licensure and certification and the duration and scope of benefits provided under the Georgia Medicaid Program.

These include:

A. Cost incurred by a hospital in meeting:

1. The definition of a hospital contained in 42 CFR 440.10 and 42 CFR 440.140 in order to meet the requirements of Section 1902(a)(13) and (20) of the Social Security Act; and

2. The requirement established by the State Agency responsible for establishing and maintaining health standards under the authority of 42 CFR 431.610; and

3. Any other requirements for licensing under the State law which are necessary for providing inpatient hospital services.

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B. Medicaid reimbursement will be limited to an amount, if any, by which the hospital's per case rate exceeds the third party payment amount for each admission.

C. Under this plan, hospitals will be required to accept Medicaid reimbursement as payment in full for services provided. As a result, there will be no Medicaid bad debts generated by patients. Bad debts will not be considered as an allowable expense.

D. The Department does not use Medicare regulations regarding payment for malpractice insurance costs. The methodology that currently is used for Medicaid will continue to be applied in the determination of allowable costs.

E. All procedures or drugs ordered by the patient's physician that result in costs being passed on by the hospital to the Georgia Medicaid Program through the cost report shall be subject to review by the Department. All procedures determined through the Department's or hospital's utilization review committee to be unnecessary or not related to the spell of illness will require appropriate adjustments to the Medicaid Log. Such adjustments for a patient may be rescinded upon a determination made by the hospital utilization review committee or the Department of Medical Assistance as being medically necessary.

F. Reimbursable costs will not include those reasonable costs that exceed customary charges except as outlined in HCFA Publication 15, Part I, Chapter 26, Section 2614 (Carryover of Unreimbursed Cost).

V. Methods and Standards for Establishing Payment Rates

A. Payment Rates:

1. Enrolled In-State Providers

Prospective reimbursement rates will be established for all participating providers in the state. The reimbursement methodology is described in Section IV.B, D and E below.

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2. Enrolled Non-Georgia Providers

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Effective with dates of admission on and after August 15, 1996, payments to non-Georgia hospitals will not be greater than the rate of payment that will be available from the Medicaid program in their home states.

Effective with dates of admission or service of July 1, 1989, and after, enrolled non-Georgia hospitals will be paid a prospective per case rate for each inpatient admission. The prospective rate will be calculated by dividing the Medicaid allowable inpatient cost by the number of Medicaid discharges, as reported in the Medicaid cost report. These base year costs will be inflated through the reimbursement year using an inflation factor of 4% per year, which approximates the overall inflation rate from the Consumer Price Index. A payment adjustment will be added to rates for those hospitals designated as disproportionate share by the Medicaid agency in the state in which the hospital is located. These disproportionate share hospitals will have an outlier payment adjustment made for medically necessary inpatient hospital admissions involving exceptionally long lengths of stay for individuals under age one. To qualify for this day outlier payment, the length of stay for individuals under age one must exceed a hospital-specific threshold, which is defined as the mean length of stay plus three standard deviations. The day outlier payment will equal the number of days stay in excess of the threshold times a hospital-specific per admission rate per day. This rate per day will be a hospital-specific per case rate divided by the hospital-specific average length of stay for all Medicaid admissions. The base period used for calculation of the threshold and the per admission rate per day will be the period on which the hospital's prospective per case rate is based. Outlier payments will be made to all hospitals for unusually costly admissions with charges exceeding established thresholds.

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3. Non-Enrolled Non-Georgia Providers

Effective with dates of admission or service of July 1, 1989, and after, inpatient services provided by non-Georgia hospitals not enrolled in the Georgia Medicaid program will be reimbursed according to rates established by the Medicaid program in the state in which the hospital is located for those procedures covered by that state. If the state in which the hospital is located reimburses DRG rates or per diem rates exceeding $999.99, reimbursement by Georgia Medicaid will be at a rate not to exceed 65% of covered charges if the procedures or services are covered by Georgia Medicaid. For certain specialized procedures (e.g., covered transplant procedures) for which services may not be available at the reimbursement rate as stated above, the Department may approve a percentage of charges rate in excess of 65%.

B. Base Periods

Effective July 1, 1991, each enrolled in-state hospital's fiscal period 1988 audited cost report will be used to determine its base period cost per admission. This report must be for a period of at least nine months. If the 1988 cost report is for a period less than nine months, then the latest audited cost report, containing at least nine months of data, will be used. If an audited cost report is not available, the cost report as filed by the hospital will be used initially. When the audited cost report becomes available and is reviewed, accepted or corrected, the hospital's rate and payment will be adjusted retrospectively. The base period cost consists of two components. The first component includes inpatient operating costs. This component is inflated by an allowable trend factor (see Paragraph E). The second component consists of depreciation and interest for major movable equipment and building and fixed equipment; it is not inflated by a trend factor. This second component is added to the inflated operating component and total costs are divided by the number of admissions in the Department's paid claims file for the base period to determine the hospital's reimbursement rate. The Department no longer provides reimbursement for return on equity costs.